

~~FOR STATE  
HEALTH DEPT.~~

Item 4 File # 906-19758-11

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm 1. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14186

1. DECEASED-NAME (Type or Print)	First John	Middle Roy	Last Batzel	20. DATE KNOWN OF ESTI- DEATH MATED	Month 10	Doy 23	Year 1968	2b. HOUR	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.	2d. HOUR	
Male	White	6/6/1900						15 M	
7a. BIRTHPLACE (State or foreign country) Pa.	7b. CITIZEN OF WHAT COUNTRY? U.S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH CALVERT						
10. CITY OR TOWN OF DEATH Barstow	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) —			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Maintenance				12b. KIND OF BUSINESS OR INDUSTRY So Md. Elec.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13b. COUNTY CALVERT	13c. CITY OR TOWN BARSTOW	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER —					
14. FATHER'S NAME John	First B	Middle BATZEL	Last	15. MOTHER'S MAIDEN NAME SARAH	First Elizabeth	Middle HYNES.	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	16c. PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 819.9	17. INFORMANT 13309-9665 - Sara Louisa Keal, S. Dakota	ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Car Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1254									
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1:00 P.M. Oct 23, 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Car Accident						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street	21f. LOCATION Street or R.F.D. No.	City or Town		County		State		
Barstow Calvert Md.									
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Issam Damalouji</u>									
EXAMINER'S NAME (Type) <u>Issam Damalouji</u>									
23a. BURIAL/CREMATION, REMOVAL (Specify)	23b. DATE Oct 26, 1968	23c. NAME OF CEMETERY OR CREMORY Bethel Cemetery	23d. LOCATION (City or Town) R.D. 2 Everett Belford, Pa						
(County) (State)									
24. FUNERAL DIRECTOR A. Harkness Son, Rockville, Md.									
ADDRESS									
25a. REC'D BY REGISTRAR OCT 25 1968				25b. REGISTRAR'S SIGNATURE Charles Judge					

8614

$$\frac{d^2\psi}{dx^2} = \frac{f}{g} \quad g \neq 0$$

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First <b>Sarah</b>	Middle <b>Eva</b>	Last <b>Batzel</b>	2a. DATE KNOWN <input type="checkbox"/> Month <b>10</b> Day <b>23</b> Year <b>1968</b> OF ESTI- DEATH MATED <input type="checkbox"/>	2b. HOUR <b>M</b>				
3. SEX <b>Female</b>	4. RACE <b>White</b>	S. DATE OF BIRTH <b>July 21, 1904</b>	6. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	IF UNDER 24 HRS. MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>23</b> Year <b>1968</b> 2d. HOUR <b>1:15 P.M.</b>			
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CALVERT.</b>					
10. CITY OR TOWN OF DEATH <b>BARTSTOW</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) —			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Home</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>CALVERT</b>			13c. CITY OR TOWN <b>BARTSTOW</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER —			
14. FATHER'S NAME First <b>Selby</b>			Middle <b>M.</b>	Last <b>Diehl</b>	15. MOTHER'S MAIDEN NAME First <b>Mary</b>			Middle <b>Ida Diehl</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>?</b>			17. INFORMANT <b>Sara Louisa Veal, S. Dakota</b>			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple fractures skull-fracture left leg</b> <b>819.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Car accident</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Car accident</b> (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>0254</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>P.M. 1:00 10/23/68</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Car accident.</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Street</b>			21f. LOCATION Street or R.F.D. No.		City or Town	County	State		
									<b>Barstow</b>	<b>Calvert</b>	<b>C.Md.</b>
22a. I certify that I took charge of the remains described above, held on <b>Autopsy</b> <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
									M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22b. DATE SIGNED <b>10-23-68</b>	
									DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	ADDRESS (Street, city, town, or county) <b>Prince Frederick, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>			23b. DATE <b>Oct 26, 1968</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Bethel Cemetery</b>			23d. LOCATION (City or Town) <b>RP#2, Everett Bedford, Pa.</b>	(County) <b>Pa.</b>	(State)
24. FUNERAL DIRECTOR <b>A.G. Harkness Son - Dist Republic, Inc.</b>			ADDRESS <b>49 Harkness Son - Dist Republic, Inc.</b>			25a. REC'D. BY REGISTRAR <b>OCT 25 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Juge</b>		

78181

8081 G S T30

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14179

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14188

1. DECEASED-NAME (Type or Print)				First <b>WESLEY</b>	Middle <b>HODGE</b>	Lost <b>BISHOP</b>	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month 10	Day 12	Year 1968	2b. HOUR 11:30
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday) YRS.	IF UNDER 1 YEAR MONTHS 3	IF UNDER 24 HRS. DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month October	Day 12	Year 1968	2d. HOUR 11:30		
Male	Colored	July 9, 1968									
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> INFANT <input type="checkbox"/>	9. COUNTY OF DEATH <b>Calvert</b>								
10. CITY OR TOWN OF DEATH <b>Frederick</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13c. CITY OR TOWN <b>Calvert</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>Calvert Port</b>								
14. FATHER'S NAME <b>Alfred Edward Bishop</b>	First Middle Last	15. MOTHER'S MAIDEN NAME <b>Dorothy Irene Hodge</b>	ADDRESS <b>mrs. Emily Bishop-Lusby, Md.</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT <b>—</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Interstitial pneumonitis (SDII)</b>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>484 X</b>											
(b) <b>—</b>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <b>—</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<b>525X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> <b>Edward F. Wilson, M.D.</b>											
ACTUAL SIGNATURE <b>Edward F. Wilson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>10-16-68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Zion Hill Church Cemetery Lusby P.O., Calvert Md.</b>	23d. LOCATION (City or Town) (County) (State)							
24. FUNERAL DIRECTOR <b>Leroy L. Berry - Huddington</b>		ADDRESS <b>—</b>	25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							
		DATE <b>OCT 16 1968</b>									

6819

8130 10 STAPLE 27 1961 1000 10000

881 81100

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14189

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit when those remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)	First	Middle	Lost	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
<b>BOSWELL WILLIAM EDWARD BOSWELL</b>				TO	1	68	7:20P M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
<b>Male</b>	<b>WHITE</b>	<b>3/24/108</b>		<b>60</b> YRS.			
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>CALVERT</b>				
10. CITY OR TOWN OF DEATH <b>PRINCE FREDERICK</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CALVERT COUNTY</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Tucker Driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Automobile Retired</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>CALVERT</b>	13c. CITY OR TOWN <b>PRINCE FREDERICK</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER —			
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost
<b>SAMUEL BOSWELL</b>				<b>BERTHA HAMMETT</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIAL SECURITY NO. <b>218-09-5095</b>	17. INFORMANT <b>Hospital Records</b>	Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4129</b> <i>Cardio Vascular</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>coronary Disease</i>							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from <b>1962</b> , 19 <b>to 10-4-</b> , 19 <b>58</b> , that (I) (we) last saw the deceased alive on <b>10-4- 1958</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>ISSAM F. DAMALOUJI</b>	DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) <b>DR. ISSAM F. el DAMALOUJI</b>	22e. ADDRESS <b>PRINCE FREDERICK, MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Oct. 8, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Ashbury Cemetery</b>	23d. LOCATION (City or Town) <b>Baltimore, Prince Co., Md.</b>	(County)		(State)	
24. FUNERAL DIRECTOR <b>G.G. Harkness &amp; Son, Port Republic, Md.</b>	ADDRESS	25a. REC'D BY REGISTRAR <b>Charles Judge</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				
DATE <b>OCT 8 1968</b>							

MARITIMAN

CALIFORNIA

PRI

SUMMER

BOSMFLT

corvijo

GOY

89 - 10-H-

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and **part I** filled in by the attending physician, **part II** should be detached for use as the burial-transit permit. Then please remove carbon papers. Please stamp **page 3** and **2** with the date of death prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14181

14190

1. DECEASED-NAME (Type or print)			First Owen	Middle Rebecca	Lost Bowen	2a. DATE OF DEATH Month 10	Doy 8	Year 68	2b. HOUR 8:30 M
3. SEX female		4. RACE Negro		5. DATE OF BIRTH 9-30-87		6. AGE (In years lost birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS    DAYS IF UNDER 24 HRS. HOURS    MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Calvert			
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert County Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Calvert		13c. CITY OR TOWN Prince Frederick		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First John		15. MOTHER'S MAIDEN NAME First Gray		16. SOCIAL SECURITY NO. 212-10-2815		17. INFORMANT Clarence M. Bowen		Address Prince Frederick	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF 4369 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 331X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept 1957, to Oct. 8, 1968, that (I) (we) last saw the deceased alive on Oct. 8 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>George J. Weems</u>		DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-9-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS George J. Weems, M.D.		23d. LOCATION (City or Town) West Port - Balt. Md.		(County) (State)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-12-68		23c. NAME OF CEMETERY OR CREMATORIAL Mt. Auburn					
24. FUNERAL DIRECTOR Troy E. Berry		ADDRESS Huntington 1		25a. REC'D BY REGISTRAR DATE OCT 14 1968		25b. REGISTRAR'S SIGNATURE George J. Weems			

Serial

18

6881 11730

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14191

14182

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, and in any event, within 24 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. DECEASED-NAME (Type or print)		First <b>SARAH</b>	Middle <b>JENNIE</b>	Last <b>BOWEN</b>	2a. DATE OF DEATH Month <b>October</b>	Year <b>1968</b>	2b. HOUR <b>10: P.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>Cauc.</b>		5. DATE OF BIRTH <b>February 6, 1883</b>		6. AGE (In years lost birthday) <b>85</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Calvert</b>		
10. CITY OR TOWN OF DEATH <b>Owings</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Padgett's Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13c. CITY OR TOWN <b>Calvert</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First <b>John</b>		Middle <b>Benjamin</b>	Last <b>Lyons</b>	15. MOTHER'S MAIDEN NAME First <b>Eliza</b>		Middle <b>Jane</b>	Last <b>Fowler</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown -----		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) -----		17. INFORMANT <b>O. Frank Bowen, Owings, Maryland 20836</b>		Address		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (o) <i>Gangrene of left leg</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>8 days</i></p> <p>4120</p> <p>Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last.</p> <p>(b) <i>Art. sel. C.V. disease</i> 5 years</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) <i>Hypertension C.V. Disease</i> 20 years</p> <p>DUE TO, OR AS A CONSEQUENCE OF</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p> <p>443 X</p>								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
<p>22a. I certify that (I) (this hospital) attended the deceased from <b>1968</b> to <b>Oct. 1968</b>, that (I) (we) last saw the deceased alive on <b>10-15 1968</b>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p> <p>22b. SIGNATURE <i>Page C. Jett</i></p>								
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS <b>Page C. Jett, M.D.</b>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <b>10-21-68</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 22, 1968</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Huntington Chr. Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Huntingtown Calvert Md.</b>		
24. FUNERAL DIRECTOR <i>Hutchinson Funeral Home</i>		ADDRESS <b>Owings, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>Oct 23 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Jett</i>		

1910]

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 68-2909-16/ce

14183

CERTIFICATE OF DEATH

14192

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death.

**Page 4 may be retained by the hospital or attending physician.**  
**10 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed in full, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print)				First	Middle	Last	2o. DATE OF DEATH Fri Month TO Year 1968	Fri Day 25 Year 1968	2b. HOUR P 4:55 M				
THOMAS EVANS BREEDEN													
3. SEX		4. RACE		S. DATE OF BIRTH			6. AGE (In years last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.	
MALE		WHITE		APRIL 10, 1886									
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH CALVERT			12b. KIND OF BUSINESS OR INDUSTRY on Steam Ships			
10. CITY OR TOWN OF DEATH PRINCE FREDERICK		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CALVERT COUNTY HOSPITAL-Ret. Ch. Engineer		12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b. COUNTY CALVERT		13c. CITY OR TOWN LUSBY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Zip Code 20657				
14. FATHER'S NAME JOHN BREEDEN (W.)		15. MOTHER'S MAIDEN NAME First LAURA V		Middle (Bruckles-?)						Address - (Same)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No, or unknown		16b. SOCIAL SECURITY NO. I78-I8-2994		17. INFORMANT Mrs. Mary Evans Breeden-Wife-Widow						Wife-Widow			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>If east failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arterio sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4500</i>													
19a. DATE OF OPERATION <i>4500</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <i>107</i>		City or Town <i>68</i>		County <i>10/26/68</i>		State			
22o. I certify that (I) (this hospital) attended the deceased from <i>Oct 28, 1968</i> , to <i>Oct 28, 1968</i> , that (I) (we) last saw the deceased alive on <i>Oct 28, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>J.W. Barnes</i>		DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>10/26/68</i>					
22d. PHYSICIAN'S NAME (Type) <i>R de Villareal</i>		22e. ADDRESS <i>56 Lenore Rd.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Wed Oct 30 1968		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION (City or Town) Brooklyn A A Co Md		(County) Md		(State)			
24. FUNERAL DIRECTOR <i>CURTIS E. EVANS</i>		ADDRESS 1400 S. Charles		BY REGISTRAR Balto Md 21280		DATE OCT 28 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

52141

8116 10 1944 111

WISCONSIN

(1944)

WISCONSIN

REPORT OF TGC 03 1944

**FOR STATE  
HEALTH DEPT.**

Item 21 Film 407  
12-6-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MARYLAND STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**14193**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File page 3 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR
<i>John Andrew Brooks</i>				<input checked="" type="checkbox"/>	10	30	1968	8940P
3. SEX	RACE	S. DATE OF BIRTH	6. AGE (in years YRS.)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
<i>M</i>	<i>W</i>	<i>3-8-10 58</i>	<i>58</i>	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	NEVER MARRIED	9. COUNTY OF DEATH				
<i>Md.</i>	<i>U.S.A.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<i>Calvert</i>	<input checked="" type="checkbox"/>			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)	12g. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY					
<i>Burma Federal</i>	<i>Calvert General Hospital</i>	<i>Retired teacher</i>	<i>Shipyard</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
<i>Md.</i>	<i>Calvert Solomons</i>	<input type="checkbox"/> YES	<input type="checkbox"/> NO					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
<i>John</i>	<i>W.</i>	<i>Brooks</i>	<i>Mary</i>	<i>Cecilie</i>	<i>Hansen</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give worker's dates of service)	17. INFORMANT	ADDRESS	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
<i>Yes</i>	<i>42-44 219-05-3091</i>	<i>Wm B. Brooks, Baltimore, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>812.9</i> Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. <i>816.4</i>								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Jacksnell skull</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Auto accident</i>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o) <i>Two car collision</i>								
19a. MEDICAL CERTIFICATION	19b. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY?					
			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR AM/PM	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) 10 30 19 68						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input checked="" type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Highway</i>	21f. LOCATION Street or R.F.D. No. City or Town <i>Calvert</i>	County <i>Md.</i>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> <i>H.W. Ward</i>								
ACTUAL SIGNATURE <i>H.W. Ward</i>	EXAMINER'S NAME (Type) <i>H.W. Ward</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) <i>During, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>1/2/68</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Solomons Methodist Cemetery</i>	23d. LOCATION (City or Town) (County) <i>Solomons Calvert, Md.</i>					
24. FUNERAL DIRECTOR <i>G.O. Harness Son, Fort Republic, Md.</i>	ADDRESS	25a. RECD BY REGISTRAR <i>NOV 4 1968</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

19123

base 1 VDN

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that Page 4 may be retained by the hospital or attending physician.

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH	Month	Day	Year	2b. HOUR		
SATIE CHARLOTTE CUNNINGHAM						Oct. 15 68			9: A M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR			
Female		Cauc.		May 8, 1878			90		MONTHS	DAYS	IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED <input checked="" type="checkbox"/>	9. COUNTY OF DEATH					
Maryland		USA		WIDOWED		<input type="checkbox"/>	Calvert					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Prince Frederick		Calvert House Nursing Home			House work			Domestic				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Maryland		Anne Arundel		Friendship		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
John		A.	Cunningham		Mary F. Leitch							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. If yes give war or dates of service		17. INFORMANT			Address					
-----		216-48-7888J1		George E. Cunningham, Friendship, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertension C. V. R. disease</i>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4120 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF C.U.A. (c) _____ DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 442X												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>59</u> , to <u>          </u> , 19 <u>          </u> , that (I) (we) last saw the deceased alive on <u>Oct. 14</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>G. J. Weems</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED Oct. 16, 1968						
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			Huntingtown, Maryland 20639							
G. J. Weems		Huntingtown, Maryland 20639										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)		(County)		(State)		
Burial		Oct. 18, 1968	Friendship Chr. Cemetery			Friendship A.A. Co. Md.						
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Hutchins Funeral Home		Owings, Md.			DATE OCT 21 1968		Charles J. Weems					

Aerial

631

31. 6. 1968 - 1000' above sea level. Slopes covered with

scrubby vegetation, some grassy areas.

Soil very thin, mostly sand.

Vegetation includes: *Acacia*, *Calliandra*, *Psychotria*, *Psychotria*.

Large trees include: *Quercus*, *Acacia*, *Psychotria*.

Small trees include: *Psychotria*, *Psychotria*, *Psychotria*.

Shrubs include: *Psychotria*, *Psychotria*, *Psychotria*.

Herbs include: *Psychotria*, *Psychotria*, *Psychotria*.

Ground cover: *Psychotria*, *Psychotria*, *Psychotria*.

Flowers: *Psychotria*, *Psychotria*, *Psychotria*.

Fruit: *Psychotria*, *Psychotria*, *Psychotria*.

Leaves: *Psychotria*, *Psychotria*, *Psychotria*.

Stems: *Psychotria*, *Psychotria*, *Psychotria*.

Bark: *Psychotria*, *Psychotria*, *Psychotria*.

Roots: *Psychotria*, *Psychotria*, *Psychotria*.

Flowers: *Psychotria*, *Psychotria*, *Psychotria*.

Leaves: *Psychotria*, *Psychotria*, *Psychotria*.

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14195

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/>	Month	Day	Year	2b. HOUR		
DELLA WINTERS DIXON						10	3	19	68 5:30			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS					2d. HOUR		
Female	White	June 13, 1891	77 YRS.							5:30		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH						
Missouri USA				WIDOWED <input checked="" type="checkbox"/>	DIVORCED <input type="checkbox"/>	Calvert						
10. CITY OR TOWN OF DEATH Prince Frederick Huntingtown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert Co. Hosp. Huntingtown, Md.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13c. CITY OR TOWN Huntington			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER Huntingtown, Md.			
13b. COUNTY Calvert												
14. FATHER'S NAME First Middle Last James M. Winters			15. MOTHER'S MAIDEN NAME First Middle Last Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 579-66-0481			17. INFORMANT J. Norval Dixon, Jr. Huntingtown, Md.			ADDRESS 20639			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) DUE TO, OR AS A CONSEQUENCE OF (c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4221 Fracture of right hip												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. 11 XX 9 25 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Subject had a fall						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) ?			21f. LOCATION Street or R.F.D. No. City or Town ? Huntington			County Calvert			State Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <i>Ronald N. Kornblum</i>		EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <input checked="" type="checkbox"/>			22b. DATE SIGNED Oct. 4, 1968	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 6, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Plum Point Chr. Cemetery		23d. LOCATION (City or Town) (County) (State) Plum Point Calvert Md.			DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county) Owings, Maryland			
24. FUNERAL DIRECTOR Hutchins Funeral Home		ADDRESS Owings, Maryland		25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Charles Judge			DATE OCT 7 1968		

2018

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14196

14187

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

1. DECEASED-NAME (Type or print)		First <b>Joseph</b>	Middle <b>Parran</b>	Last <b>Gouldsbrough</b>	2a. DATE OF DEATH Month <b>10</b>	Day <b>1</b>	Year <b>1968</b>	2b. HOUR <b>9:10 a.m.</b>
3. SEX <b>male</b>		4. RACE <b>white</b>		S. DATE OF BIRTH <b>1-14-04</b>	6. AGE (In years last birthday) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Calvert</b>			
10. CITY OR TOWN OF DEATH <b>Prince Frederick</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Calvert County Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Mill Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Charles</b>		13c. CITY OR TOWN <b>Nanjemoy</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Nanjemoy, Maryland</b>		
14. FATHER'S NAME First <b>Joseph</b>		Middle <b>Gouldsbrough</b>	Last <b></b>	15. MOTHER'S MAIDEN NAME First <b>Mary</b>	Middle <b></b>	Last <b>Brown</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>214-16-7307</b>		17. INFORMANT <b>Nina McCoy</b>	Address <b>Nanjemoy, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <p>PART I. DEATH WAS CAUSED BY:  <b>IMMEDIATE CAUSE (a)</b> <i>Heart Failure - Bronxer</i>  <b>4290</b>  <b>DUE TO, OR AS A CONSEQUENCE OF</b>  <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <i>Arteries</i>  <b>(b)</b> <i>Arteries</i>  <b>DUE TO, OR AS A CONSEQUENCE OF</b>  <b>(c)</b> <i>Arteries - heart</i> </p>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4344</b>								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 14, 1968</b> to <b>October 11, 1968</b> , that (I) (we) last saw the deceased alive on <b>Sept. 30, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>J. de Villarreal</i>		DEGREE <b>M.D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>10/1/1968</b>		
22d. PHYSICIAN'S NAME (Type) <b>Roberto de Villarreal, M.D.</b>		22e. ADDRESS <b>St. Leonard, Maryland</b>						
23a. BURIAL, CREMATION, REMAINS <b>Burial</b>		23b. DATE <b>10/4/1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Trinity Mem. Gardens</b>		23d. LOCATION (City or Town) <b>Waldorf, Maryland</b>	(County) <b></b>	(State) <b></b>	
24. FUNERAL DIRECTOR <b>Arehart Funeral Home, Inc. - La Plata, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	DATE <b>OCT 7 1968</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14197

## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. <sup>Page 1 and 2</sup>  
director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. <sup>Page 1 and 2</sup>  
should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First <b>William</b>	Middle <b>Jefferson</b>	Last <b>Golihow</b>	2a. DATE OF DEATH Month <b>October</b>	Day <b>8</b>	Year <b>68</b>	2b. HOUR <b>11:30P.M.</b>					
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>10-17-02</b>		6. AGE (In years last birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR MONTHS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b>		MIN. <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Calvert</b>								
10. CITY OR TOWN OF DEATH <b>Pr. Frederick</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Calvert County Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Cab driver</b>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Calvert</b>	13c. CITY OR TOWN <b>North Beach</b>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>507 Dayton Ave.</b>								
14. FATHER'S NAME First <b>John</b>	Middle <b>Golihow</b>	Last	15. MOTHER'S MAIDEN NAME First <b>Bessie</b>	Middle	Last <b>Staples</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>	16b. SOCIAL SECURITY NO. <b>579-24-8930</b>	17. INFORMANT <b>WIFE</b>	Address <b>Nellie Golihow, North Beach, Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Dystrophy</b>							APPROXIMATE INTERVAL BETWEEN DISSET AND DEATH					
4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause <b>last.</b>												
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>												
19a. DATE OF OPERATION <b>4/20/1</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <b>9/22</b> , 19 <b>68</b> , to <b>10/8</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>9/22</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>J. Weems</b>		DEGREE <b>M.D.</b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>10/11/68</b>						
22d. PHYSICIAN'S NAME (Type) <b>George J. Weems, M.D., Huntingtown, Md.</b>		22e. ADDRESS <b>WASH NATH CEMETERY SUITLAND MD</b>										
23a. BURIAL, CREMATION <b>Burial</b>		23b. DATE <b>10-11-68</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>WASH NATH CEMETERY SUITLAND MD</b>		23d. LOCATION (City or Town) (County) <b>SUITLAND MD</b>							
24. FUNERAL DIRECTOR <b>H.W. Chambers Co</b>		ADDRESS <b>517-11st St. D.C.</b>	25a. REC'D. BY REGISTRAR DATE <b>OCT 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

TELE

RECORDED INFORMATION

SOURCE

MANUFACTURER

MADE IN U.S.A. BY THE NATIONAL COMPANY

PRINTED IN U.S.A. BY THE NATIONAL COMPANY

PRINTED IN U.S.A. BY THE NATIONAL COMPANY

PRINTED IN U.S.A. BY THE NATIONAL COMPANY

100

000111700

14189

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

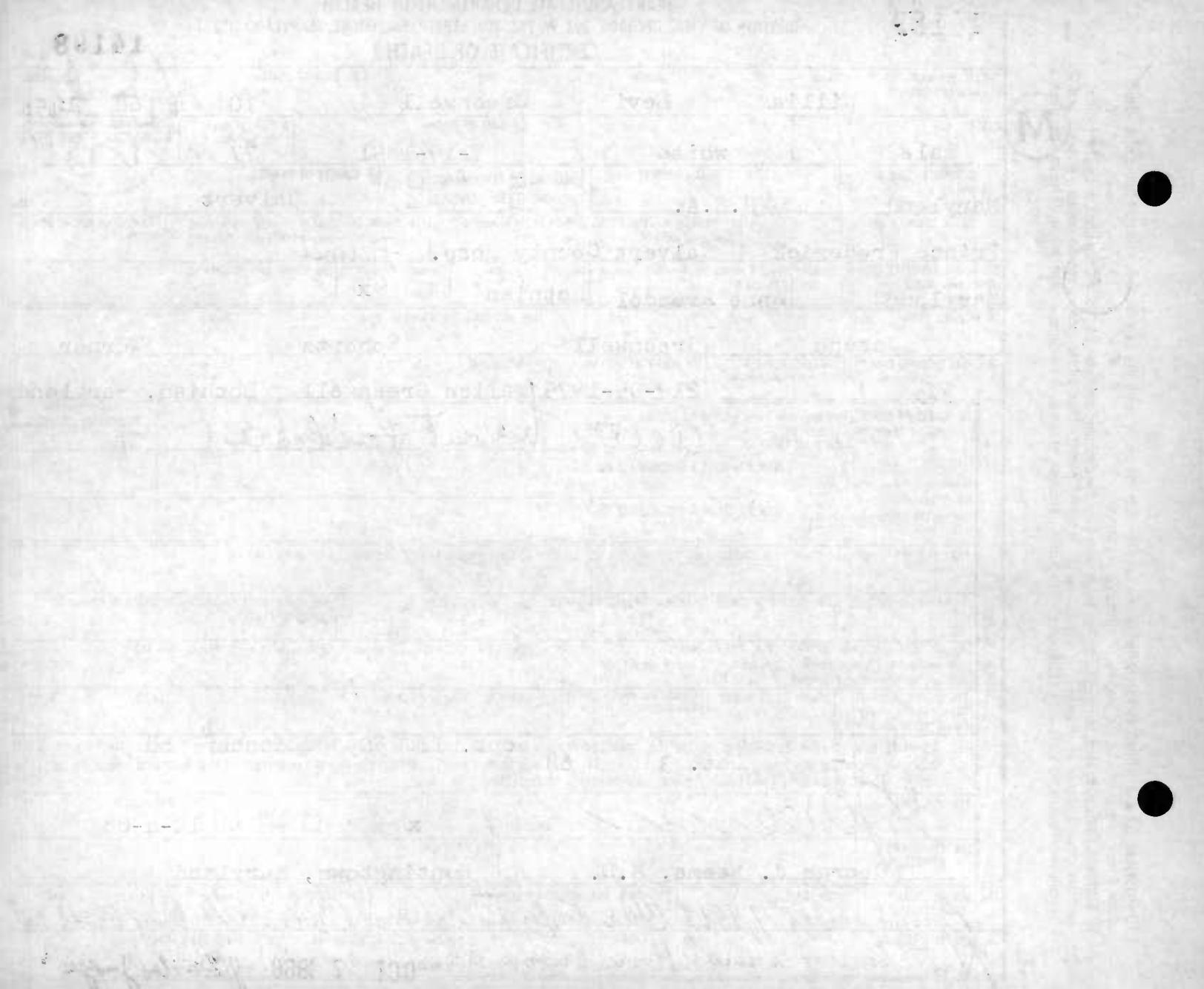
CERTIFICATE OF DEATH

14198

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
 Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)			First <b>William</b>	Middle <b>Levi</b>	Last <b>Greenwell</b>	2a. DATE OF DEATH Month <b>10</b>	Day <b>4</b>	Year <b>60</b>	2b. HOUR <b>1:15 a.m.</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>	5. DATE OF BIRTH <b>7-19-1891</b>			6. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR MONTHS <b>0</b>		IF UNDER 24 HRS. DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Calvert</b>						
10. CITY OR TOWN OF DEATH <b>Prince Frederick</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Calvert County Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Palmer</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Anne Arundel</b>	13c. CITY OR TOWN <b>Lothian</b>		13d. INSIDE CITY LIMITS? <b>YES</b>	13e. STREET AND NUMBER <b>Lothian, Maryland</b>						
14. FATHER'S NAME First <b>Joseph</b>			Middle <b>Greenwell</b>	Last <b></b>	15. MOTHER'S MAIDEN NAME First <b>Roberta</b>			Middle <b></b>	Last <b>Turner</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-05-1975</b>			17. INFORMANT <b>Alice Greenwell</b>		Address <b>Lothian, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute heart failure</b>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
7824 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 7824												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.			City or Town		County	State			
22a. I certify that (s) (this hospital) attended the deceased from Sept. 11, 1950, to October 19, 1968, that (I) (we) last saw the deceased alive on Oct. 3 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>G. Weems</b>		DEGREE <b></b>	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>10-4-68</b>						
22d. PHYSICIAN'S NAME (Type) <b>George J. Weems, M.D.</b>		22e. ADDRESS <b>Huntingtown, Maryland</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct 7, 1968</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Our Lady of Sorrows Cemetery</b>			23d. LOCATION (City or Town) <b>Owensville</b>		(County) <b>Anne Arundel</b>	(State) <b>Md.</b>			
24. FUNERAL DIRECTOR <b>Hutchins Funeral Home Owings Mills</b>		ADDRESS <b></b>			25a. REC'D BY REGISTRAR <b></b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					
					DATE <b>OCT 7 1968</b>							



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14199

7  
14190  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

5 may be retained for your files.

1. DECEASED NAME (Type or Print)	First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR
Francis Atlee			GriFFin	10	16	68	11:30A	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years from birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
M	W	Mar 22, 1904	64 yrs.	MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	9. COUNTY OF DEATH					
Ga	U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Calvert					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY					
Ches Beach		Brick Layer	Building					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER					
X	Calvert	C. Beach	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last	
John	S	GriFFin	Carry Belle					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No	577-14-7735	Mrs F A GriFFin, C.B. Md		9 mo				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) 1621 Due to, or as a consequence of								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) last. 163 X Due to, or as a consequence of								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)								
Had bee x Operated upon 1x Jan 1968								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?						
Jan 1968	Op of Lungs	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State			
22o. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE	H.W. Ward			CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	22b. DATE SIGNED	10/16/68	
EXAMINER'S NAME (Type)	H.W. WARD			M.D.	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE Burial Oct 18, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Fort Lincoln Cemetery	23d. LOCATION (City or Town) Bladensburg Rd. Wash. DC	(County)	(State)			
24. FUNERAL DIRECTOR	ADDRESS Hutchinson Funeral Home Owings, Md.	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE					
DATE OCT 21 1968								

CEP 1

TESTIMONIALS FROM THE 1941 CLOTHING SURVEY  
11-10-370101-12-1941-1941

8281 12700

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that Page 4 may be reprinted by the hospital or attending physician

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the director, page 3 should be detached for use as the burial/transplantation certificate.

1. DECEASED-NAME (Type or print)			First	Middle	Last	2d. DATE OF DEATH	2d. HOUR	
Maria			--		LeBark	Month 10 Day 3 Year 1968	1205PM	
3. SEX		4. RACE	S. DATE OF BIRTH			6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
female		white	9-2-1900			68 yrs.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			
Austria Germany		U.S.A.	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Calvert			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
Prince Frederick			Calvert County Hosp.			housewife		Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Calvert		13c. CITY OR TOWN Prince Frederick	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER -- Goldstein Rd--	
14. FATHER'S NAME			First Sehald	Middle --	Last Springer	15. MOTHER'S MAIDEN NAME	First Anna	Middle Robsl
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO. 577-05-2571		17. INFORMANT	Upper Marlboro, Md.		
			(If yes give war or dates of service)		Ann LeBark,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 <i>Coronary Thrombosis</i> APPROXIMATE INTERVAL DUE TO, OR AS A CONSEQUENCE OF 4 days								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause (b) _____ last. DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hypertension CVD</i> _____								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. 19 P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Month Day Year				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from Sept. 28, 1968, to Oct. 3, 1968, that (I) (we) last saw the deceased alive on Oct. 3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>Roberto de Villarreal</i>			DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10-4-68	
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS St. Leonard, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10/7/68	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Carmel Cemetery			23d. LOCATION (City or Town) Upper Marlboro	(County) P.Geo.Md.	(State)
24. FUNERAL DIRECTOR Ritchie Bros. Upper Marlboro, Md.			ADDRESS			25a. RECEIVED BY REGISTRAR OCT 14 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

INTEN

re mince -- blade

-- or fine and

fine

Fine mince

Coarse mince

FOR STATE  
HEALTH DEPT.

14192

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil, in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print)	First	Middle	Lost	2a. DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input type="checkbox"/> 10/4/1885 5:15 PM	2b. HOUR <input type="checkbox"/>		
WALTER	HERMAN	LONG					
3. SEX MALE	RACE WHITE	S. DATE OF BIRTH MAR. 14, 1880	16. AGE (in years last birthday) 88 yrs.	IF UNDER 1 YEAR MONTHS OAYS	IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) ARKANSAS	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH CALVERT	2c. DATE PRONOUNCED DEAD Month 10 Day 4 Year 1885 5:45 PM			
10. CITY OR TOWN OF DEATH PRINCE FREDERICK, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CALVERT COUNTY	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND	13b. COUNTY PR. GEORGE	13c. CITY OR TOWN LANHAM	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER (9144) BROWNS LANE			
14. FATHER'S NAME DANIEL UNKNOWN LONG	First	Middle	Lost	15. MOTHER'S MAIDEN NAME UNKNOWN	First	Middle	Lost
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 578-03-9210	17. INFORMANT DANIEL B. LONG ADDRESS 6922 SHEFFIELD PR. SPRING, MD	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 890 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF INHALATION (c) DUE TO, OR AS A CONSEQUENCE OF PULMONARY Edema.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 916-0							
19a. MEDICAL CERTIFICATION 19a. DATE OF OPERATION 10-4-68		19b. CONDITION FOR WHICH OPERATION TRACHEOTOMY WAS PERFORMED Burning & Swelling of mucous		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) FIRE IN HOUSE			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) HOME		21f. LOCATION Street or R.F.D. No. City or Town County State North Beach Calvert Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE ISSAM F. elDAMALOUJI EXAMINER'S NAME (Type) DR. ISSAM F. elDAMALOUJI							
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE 10-8-68		23c. NAME OF CEMETERY OR CREMATORIAL Redan Hill Cem		23d. LOCATION (City or Town) (County) (State) Gulfland Md	
24. FUNERAL DIRECTOR W.W. Chambers Co		ADDRESS 517 11th St. S.E. Washington		25a. REC'D BY REGISTRAR DATE OCT 9 1968		25b. REGISTRAR'S SIGNATURE jCharles Juge	

10221

882-F-100

**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**11 FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. **PAGES** and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## **CERTIFICATE OF DEATH**

14202

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR			
Agnes Victoria Lusby						Month	10	Day	2	Year	68	
3. SEX		4. RACE		S. DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		02-23-09			59		MONTHS	0	HOURS	0
7b. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH						
Maryland		U. S. A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Calvert County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Prince Frederick			Calvert County Hospital			(Invalid)			Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Md.			Calvert			Solomons						
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last	
Albert				Parks		Florence			M	Elliott		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
						Mrs. Peggy Shenton			Solomons, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <i>Heart Failure</i>												
4109 Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) <i>Conway Decubitus</i> (c) <i>Chronic Thromboembolic</i>												DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from 9-20, 1968, to 10-2, 1968, that (I) (we) last saw the deceased alive on 10-2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Roberto de Villarreal</i>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-3-68
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			St. Leonard, Maryland						
Roberto de Villarreal, M.D.												
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <i>Oct. 5, 1968</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>Solomons Meth. Cemetery</i>		23d. LOCATION (City or Town) <i>Solomons, Calvert, Md.</i>		(County)		(State)		
24. FUNERAL DIRECTOR		ADDRESS				25a. REC'D BY REGISTRAR <i>OCT 4 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
<i>G.A. Narvaez Son, Mort Republic, Md.</i>												

SORRY

Sheet 1 700

## MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 14 Film 6106 10/20/68

## CERTIFICATE OF DEATH

14194

14203

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. In any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First Rose	Middle C	Last Meyer	2a. DATE OF DEATH Month 10	Day 11	Year 68	2b. HOUR 7:30 A.M.	
3. SEX female	4. RACE white	5. DATE OF BIRTH July 9, 1877			6. AGE (In years last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Calvert					
10. CITY OR TOWN OF DEATH St. Leonard	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Long Beach -	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired			12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13c. CITY OR TOWN St. Leonard	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER —					
14. FATHER'S NAME First Joseph Middle Crovo Last Henry J. W. H. Meyer	15. MOTHER'S MAIDEN NAME First Anna	Middle M.	Last Leverone					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16b. SOCIAL SECURITY NO. 215-48-2292	17. INFORMANT Louis S. Baker	Address St. Leonard, Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart failure DUE TO, OR AS A CONSEQUENCE OF (c) Generalized sclerosis								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201								
19a. DATE OF OPERATION X		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County	State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE J. Williamson		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 10-11-68			
22d. PHYSICIAN'S NAME (Type) St. Leonard, Md.		22e. ADDRESS Roberto de Villegas, M.D. St. Leonard, md.						
23a. BURIAL, CREMATION REMOVAL (Specify) Funeral		23b. DATE Oct. 15, 1968	23c. NAME OF CEMETERY OR CREMATORIUM Rock Creek Cemetery			23d. LOCATION (City or Town) Washington (County) D.C. (State)		
24. FUNERAL DIRECTOR A. G. Harkness & Son, Port Republic, Md.		ADDRESS			25a. REC'D BY REGISTRAR DATE OCT 15 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14195

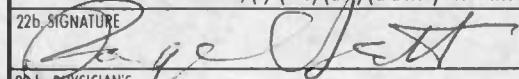
CERTIFICATE OF DEATH

14204

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.

**Page 4 may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First  Leslie	Middle  Plater	Last	2a. DATE OF DEATH Month 10	Doy 18	Year 68	2b. HOUR p.m. 1230M
3. SEX		4. RACE  male	S. DATE OF BIRTH  14-5-06	6. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR MONTHS OAYS			IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Calvert				
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert County Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Labor		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Calvert	13c. CITY OR TOWN Sunderland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Sunderland, Md.			
14. FATHER'S NAME		First  Alexander	Middle  Plater	Last	15. MOTHER'S MAIDEN NAME	First  Mary	Middle	Last  Harvey
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 220-16-8498		17. INFORMANT Katherine Freeland		Address Sunderland, Md.		
18b. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <u>185X</u> DUE TO, OR AS A CONSEQUENCE OF <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause</b> <u>(b)</u> <u>probably recurrent prostatitic malignancy</u> DUE TO, OR AS A CONSEQUENCE OF <u>(c)</u>								
<b>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</b> <u>177X</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (if either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Doy Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to Oct. 18, 1968, that (I) (we) last saw the deceased alive on Oct. 18, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE 		DEGREE ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) Page C. Jett, M.D.		22e. ADDRESS Prince Frederick, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) 10/22/68		23b. DATE 10/22/68	23c. NAME OF CEMETERY OR CREMATORIAL Bethel Way CH. Cem.		23d. LOCATION (City or Town) (County) (State) Calvert Co., Md.			
24. FUNERAL DIRECTOR Pinckney E. Swell		ADDRESS Prince Frederick, Md.	25a. REC'D BY REGISTRAR DATE OCT 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

20287

1940 DEATHS

5

DEATHS  
REGISTRATION  
1940

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14196

14205

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician or attending physician's director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First <i>Edua.</i>	Middle <i>Helen</i>	Lost <i>Rawlings</i>	20. DATE OF DEATH Month 10	Doy 9	Year 1968	2b. HOUR 12:30 P.M.
3. SEX <i>Female</i>		4. RACE <i>Negro</i>	5. DATE OF BIRTH <i>11-15-15</i>		6. AGE (In years last birthday) 52 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Calvert</i>		
10. CITY OR TOWN OF DEATH <i>Prince Frederick</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Calvert County Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Calvert</i>		13c. CITY OR TOWN <i>Owings</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
14. FATHER'S NAME First <i>Henry</i>		Middle <i>Holland</i>	Last	15. MOTHER'S MAIDEN NAME First <i>Irene</i>		Middle <i>Giles</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <i>219-36-8306</i>		17. INFORMANT <i>Ashby Rawlings, Jr.</i>		Address <i>Owings, Md.</i>		
<p>18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>401X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>a</i> <i>UREMIA.</i> stating the underlying cause lost.</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>								
<p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o)</p> <p><i>444X</i></p>								
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING □ OR CONTRIBUTING □ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
<p>22a. I certify that (I) (this hospital) attended the deceased from <i>1967</i>, 19<i>68</i>, to <i>10-9-1968</i>, that (I) (we) last saw the deceased alive on <i>10-4-1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.</p>								
22b. SIGNATURE <i>J. Amalouji</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED <i>10-9-68</i>		
22d. PHYSICIAN'S NAME (Type) <i>J. Amalouji</i>		22e. ADDRESS <i>Prince Frederick, Maryland</i>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>St. Edmond Ch. Cem.</i>		23b. DATE <i>10-12-68</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Edmond Ch. Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Sunderland Cal. Md.</i>		
24. FUNERAL DIRECTOR <i>Franklin E. Seewell Prince Fred. Md.</i>		ADDRESS		25a. REC'D BY REGISTRAR DATE <i>OCT 14 1968</i>		25b. REGISTRAR'S SIGNATURE <i>James George</i>		

202A1

116-0-22081

WOMEN 4-33-A-14

4-33-A-14

202 100

100

116-0-22081 WOMEN 4-33-A-14 4-33-A-14

202 100

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14197

14206

2d. HOUR

To HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED-NAME (Type or print)				First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2d. HOUR			
				Ellis	Washington	Robinson	10	11	1968	3:15a			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNOFR 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.	
male		white		3-22-13			55 yrs.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Calvert			
Maryland		U.S.A.											
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Prince Frederick				Calvert County Hosp.			Diesel Mechanic			U.S. Gov.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER			
Maryland				Calvert			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			—			
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last			
		Washington		Robinson				Lillian		Greaves			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT			Address			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
no		218-12-2377		Clara Ruth Robinson			Solomons, Md.			36mld			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circumstances</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Ca J hung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>163X</u>													
19a. MEDICAL CERTIFICATION DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		2db. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State			
22a. I certify that (I) (this hospital) attended the deceased from Jan. 1, 1967, to Oct. 11, 1968, that (I) (we) lost saw the deceased alive on Oct. 10, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Roberto de Villarreal</u>		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR		<input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 10-11-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS Roberto de Villarreal, M.D. St. Leonard, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE Oct 13, 1968		23c. NAME OF CEMETERY OR CREMATORIAL Solomons Methodist Cemetery			23d. LOCATION (City or Town) Solomons, Calvert Co., Md.		(County)		(State)		
24. FUNERAL DIRECTOR		ADDRESS A.A. Harkness & Son, Port Republic, Md.		25a. REGD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 15 1968				

Digitized by srujanika@gmail.com

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death if delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14207

1. DECEASED NAME (Type or Print)	First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Doy	Year	2b. HOUR	
1. DECEASED NAME (Type or Print)	<i>Lawry Griffis Sherman</i>			<input checked="" type="checkbox"/>	10	3	1968	05 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years at birthday) YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD Month Day Year	
W	W	W 12-24-64	74					10 3 1968	
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH						
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during time of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Ches Beach				<i>Retired</i>		<i>Jagf</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNT	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER					
Md		Ches Beach	X						
14. FATHER'S NAME	First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost		
Richard Sherman				Winnie July					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT	ADDRESS						
NO	57707-238	H. B. Sherman	Ches Beach 10						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>Cardiac failure</i>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <i>Congestive heart failure</i>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <i>Obstruction of airways</i>									
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<i>Had an attack of asthma</i>									
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
MEDICAL CERTIFICATION									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.			City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>H. W. Ward</i>									
EXAMINER'S NAME (Type) <i>H. W. Ward</i>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/>									
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>									
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
ADDRESS (Street, city, town, or county) <i>Bladensburg Rd. Wash. D.C.</i>									
22b. DATE SIGNED <i>10/3/68</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <i>Oct 5, 1968</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln</i>	23d. LOCATION (City or Town) (County) (State)						
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE						
<i>Hutchins Funeral Homes Owings, Md</i>									
DATE OCT 7 1968 <i>Charles Judge</i>									
VR A15ME 10 10M REV. 1/68									

VOCA)

REP 1 100

Item 4 FilmG406 10/31/68 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14208

1. DECEASED NAME (Type or print)		First RUFUS	Middle HENRY	Last TAYLOR	2a. DATE OF DEATH Month 10	Day 21	Year 68	2b. HOUR 2a.m
3. SEX MALE		4. RACE NON-WHITE/ Negro		5. DATE OF BIRTH 7/9/99		6. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CALVERT COUNTY		Md.
10. CITY OR TOWN OF DEATH Prince Frederick		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Calvert House		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. CITY OR TOWN Calvert		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
14. FATHER'S NAME First EDWARD		Middle TAYLOR	Last	15. MOTHER'S MAIDEN NAME First AGNES		Middle	Last REED	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Unknown		16b. SOCIAL SECURITY NO. 213-12-3290		17. INFORMANT Madelyn Rawlings		Address Prince Fred. Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Circulatory collapse.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the <u>underlying cause</u> last. (b) <u>Coronary Stomach - Liver.</u> DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)								
19a. DATE OF OPERATION 1519		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <i>John F. Ross</i>		DEGREE ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-26-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-26-68	23c. NAME OF CEMETERY OR CREMATORIUM Moses Cem.			23d. LOCATION (City or Town) A.A.Co.		(County) Md. (State)
24. FUNERAL DIRECTOR <i>Linkney E. Service Prince Fred. Md.</i>		ADDRESS ADDRESS DAT OCT 28 1968						
		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Please send to the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

60341

60341 6 STOO